The mission of Independent Audiologists Australia is to promote and support clinical practices owned by audiologists.

Independent audiologists australia

Medicare Benefits Schedule-
Review Taskforce

mbsreviews@health.gov.au

20 December 2019

Dear Taskforce and Clinical Committee Members

Report from the Otolaryngology, Head and Neck Surgery Clinical Committee

Thank you for the opportunity to provide comment on the report from the Otolaryngology, Head and Neck Surgery Clinical Committee, 2019.

Independent Audiologists Australia Inc (IAA) is a not for profit incorporated association whose members are university qualified Audiologists holding a financial interest in an audiology practice owned at least 50% by Audiologists. Our members operate more than 400 clinic sites across Australia and are signatories to our code of ethics and practice standards that require, amongst other things, transparency in billing and in conflict of interest. Our members access public funding from the Hearing Services Program (HSP), Department of Veterans Affairs (DVA), National Disability Insurance Scheme (NDIS) as well as private health funds. Our members are Medicare providers in their own right holding an allied health Medicare provider number. Audiologists are also third-party providers of services funded by Medicare when working under the supervision and billing on behalf of a Medicare provider Medical Specialist.

Clinical Audiology is described in the report from the Otolaryngology, Head and Neck Surgery Clinical Committee to the MBS Review Taskforce as “a branch of medicine that studies hearing, balance and related disorders”. Audiologists provide diagnostic and rehabilitative services for those of all ages affected by the full range of auditory and vestibular (hearing and balance) disorders– be they related to sensory impairment, processing, cognition, or language as stand-alone conditions or co-morbid with other medical conditions.

Diagnostic audiology is a specialised service that assess auditory and vestibular function. Diagnostic audiology tests are used to identify the presence, the type and the degree of hearing and balance disorders and contributes to ascertain the site of the lesion. Diagnostic audiology, like any diagnosis, is a process where the choice of appropriate tests relies on individual results.

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Audiologists perform, interpret and integrate audiological tests following the case history and clinical observation. Audiologists provide a comprehensive report with test results to General Practitioners and Medical Specialists for further assessment and/or treatment whenever required according to clinical findings.

Audiological diagnosis is reached using an appropriate test battery for each individual case. Currently, diagnostic audiology when conducted to assess auditory function may include case history, otoscopy, wax removal by curette or suction, pure tone audiometry via air and bone conduction with masking when appropriate, speech audiometry, immittance measurements (tympanogram and acoustic reflexes), distortion product otoacoustic emissions, transient otoacoustic emissions, electrocochleography, auditory evoked brainstem responses, steady state responses, middle latency responses, cortical responses, P300, mismatch negativity, subjective auditory processing tests such as speech in noise, dichotic tests, gaps in noise, and listening in spatialized noise.

Current diagnostic tests to assess vestibular function may include Dix-Hallpike manoeuvre and other positional tests, video/electro nystagmography, oculography, caloric tests, rotatory chair, balance platform, video head impulse tests, subjective visual vertical test, cervical vestibular evoked potentials (cVEMP) and ocular vestibular evoked potentials (oVEMP) via air and bone conduction.

Audiological procedures are lengthy and require expensive equipment with disposable materials. A basic audiological evaluation including history, otoscopy, pure tone audiometry, speech audiometry and immittance tests may take up to 1 hour. All the other procedures take at least 20 minutes each.

Abnormal audiological findings are usually directly related to a disease of the ear but may also be the first sign of chronic and/or conditions such as diabetes, kidney disease, cardio-vascular disorders, stroke and brain tumours, amongst others.

Audiologists are frequently the primary health care provider for those with hearing and/or balance loss. Under the current Medicare rules however, Audiologists cannot refer directly to a Medical Specialist so that they usually advise their patients to seek a referral from their General Practitioner. A direct pathway from Audiologists to Medical Specialists is reasonable and necessary and would translate into significant savings of resources including time and money.

Long term care for those with hearing and balance disorders requires Audiologists to be in communication with General Practitioners and other Medical Specialists providing ongoing care. Many patients will have audiology as part of a chronic disease management plan.

Audiologists also provide rehabilitative audiology for those who cannot have their hearing and balance issues remediated by medical intervention alone. Audiologists prescribe and dispense technological aids (including wearable and implantable devices), deliver assessment driven support, communication training and counselling as (re)habilitation to both individuals and their significant others, all of whom are impacted when hearing and balance conditions are present in the family or community.

Considering the above, we provide specific suggestions and comment on the recommendations made to the MBS Review Taskforce by the committee that has produced the initial recommendations to revise certain Medicare items. Our comments are focussed on audiology and related Medicare items under review. We provide an overall suggestion to revise MBS items to recognise contemporary audiological practice. We do, however, also make specific comment on the proposed changes to existing MBS item numbers.

MBS Item Numbers to reflect contemporary Audiological Practice

Diagnostic Audiology item numbers introduced in 2012 required a request by a Medical Specialist (0tolaryngology head and neck surgeon or neurologist) to an Audiologist to perform specific procedures.

The committee proposes referral to audiology by any medical practitioner. We fully support extending access to Audiologists to all patients under Medicare, regardless of which medical specialty is attending to them. Direct access to audiology services upon a general practitioner's referral is more economical both in the finance and time domains, as patients will not have to wait and pay to consult with a specialist prior to undergoing audiological diagnostic tests.

Audiologists specialise in hearing and balance function and the only professional with a minimum of 5 years of full-time training in this specialty before entering the workplace, 2 years of which are at the postgraduate Masters level. Medical students have only a few hours on the subject of hearing and balance during their training while Ear Nose and Throat specialists focus their training on the medical and surgical aspects of disorders, not the audiological aspects. Audiologists thus should be recognised as trained and qualified allied healthcare professionals who specialise in hearing and balance.

We strongly support that patients are referred to Audiologists for audiological assessment, and that the test items are selected by the treating Audiologist.

A new referral pathway allowing Audiologists to receive referrals from any Medicare provider and to receive the appropriate Medicare funding would allow Australians to receive the best possible audiological care in a timely manner.

The current system of listing specific procedures reflects neither the role of the Audiologist in selecting appropriate measures, nor innovation and new developments that emerge in the field of audiology.

We object to Medicare funding for Audiologists to carry out diagnostic audiology requests only for specific procedures because medical practitioners cannot anticipate test results to the extent that they will know which tests are possible or necessary to reach either an audiological or medical diagnosis. The process of selecting appropriate tests occurs during the audiological assessment conducted by the Audiologist, the professional with appropriate and sufficient training do so.

The committee has recognised this fundamental principle of audiological assessment in their proposal that MBS items pertaining to vestibular assessment should relate to the number of procedures undertaken. To reflect contemporary audiological practice, the same principle should not only apply to vestibular assessment but also to auditory assessment.

We regret that the committee has not considered removing the audiology test items from MBS items "owned" by ENT Specialists and Neurologists, in favour of funding only Audiologists to perform audiological procedures. Given that parallel item numbers for both Medical Specialists and Audiologists are likely to remain within the MBS system based on the committee's report, equal pay for equal work is our minimum demand. Medicare fees paid for items provided on behalf of Medical Specialists should be identical to the same procedures performed and billed to Medicare by Audiologists. Identical pay is highly justified because the cost of conducting auditory and vestibular tests (equipment, calibration, disposables, professional time, reporting) is the same for both arrangements. Medical Specialists can bill Medicare for a consultation on top of the test procedures which we believe reflects any additional medical diagnosis or medical prescribing that the Medical Specialist will make.

Disparity in Medicare fees paid to Medical Specialists in comparison to Audiologists for the same procedures can be interpreted as lack of professional respect for the training and expertise required to work as an Audiologist. As Audiologists we highly respect our Medical Specialist colleagues for their knowledge and expertise and the role they play in the team care of patients with hearing and balance loss. In many cases respect by Medical Specialists for Audiologists is reciprocated in clinical practice. We call for a Medicare system that reflects the respect for all team members who contribute to contemporary healthcare, and strongly urge rules associated with MBS item numbers to do the same.

In summary, we strongly urge the committee to:

1. Recognise that formal education in Audiology is the requirement to conduct audiology work funded by Medicare.

2. Propose new MBS items for both auditory and vestibular assessment that relate to the number of procedures carried out, following the principles introduced into the report on Page 29 and 30 of the report.

3. Propose that one set of MBS items (with the same fee) should be claimable by Audiologists who either undertake those assessments themselves or undertake them on behalf of a Medical Specialist, and further that Medical Specialists be required to outsource only to qualified Audiologists for these items when billing to Medicare under their own provider number.

In the absence of reform as described above, we believe that many of the proposed changes suggested in the report have merit, although further changes are needed to bring existing MBS items in line with contemporary practice, as we show below.

4.1.1 Brainstem Evoked Response Audiometry (Page 18 ff) (MBS 11300 / 82300)

We propose that this item name is changed to Auditory Evoked Potentials and that it is allowed to be billed to Medicare multiple times on the same day for the same patient using the same provider number to reflect all necessary procedures performed to reach a conclusion, The tests performed under this item should be: electrocochleography, auditory brainstem, midbrain, cortical or vestibular myogenic potentials.

Furthermore, this item has been approved for use when programming an implantable hearing devices. We propose that a new item is created to reflect the appropriate procedure and that the new item is named Programming of a Hearing Device.

4.1.3 – Impedance Audiogram

We support simplifying this item number however we suggest the terminology should be updated. The term “Immittance Measures” or “Middle Ear Analysis” is used in contemporary audiology to describe *those measures involving tympanometry and acoustic reflex.*

4.1.6 – Paediatric Loading

As mentioned above, we support a loading for paediatric audiology.
However, we believe the terminology in the report (see page 32) is dated. Reinforcement used in paediatric assessments referred to in the report as a “puppet show” is very limiting as various forms of reinforcement may be used, depending in the age and ability of the child.

4.3.13 Otology - Ear Toilet

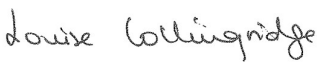
The committee recommends specifying MBS item 41647 is not for the uncomplicated removal of wax and debris from the ear canal. Whilst we recognise a difference between uncomplicated removal of wax and debris and the inspection of the ear canal to diagnose ear pathology, Audiologists undertake otoscopic examination of the ear canal to routinely prepare the ear canal for audiological examination using otoscopes and microscopes and remove cerumen and debris using a curette or micro-suction therefore should be able to bill Medicare for this service.

In summary, the feedback to the committee and the task force presented above is intended to result in an equitable, fair and simple MBS system for audiology that benefits the public, ensures that audiological services are accessible and sufficiently comprehensive to address the hearing and balance needs of all Australians eligible to Medicare.

We welcome any further opportunities to discuss Medicare funding of audiology.

Kind regards

Independent Audiologists Australia Inc



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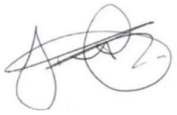

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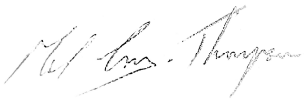

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